Washington State
House of Representatives
Office of Program Research

BILL ANALYSIS

Health Care & Wellness Committee

HB 2319

Brief Description: Implementing the affordable care act.

Sponsors: Representatives Cody, Jinkins and Ormsby; by request of Governor Gregoire and Insurance Commissioner.

Brief Summary of Bill

- Removes the limitations on the Health Exchange Board's authority regarding operating the health benefit exchange.
- Imposes requirements on qualified health plans that sell coverage through the Health Benefit Exchange.
- Changes the definition of "catastrophic health plan."
- Imposes restrictions on carriers that sell coverage outside of the Health Benefit Exchange.
- Limits the Washington State Health Insurance Pool to persons enrolled prior to December 31, 2013, who do not disenroll after December 31, 2013.
- Removes the ability of Washington State Health Insurance Pool plans to impose pre-existing condition waiting periods beyond December 31, 2013.

Hearing Date: 1/18/12

Staff: Jim Morishima (786-7191).

Background:

I. Health Benefit Exchanges.

The federal Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act of 2010 (ACA) requires every state to establish a Health Benefit Exchange (Exchange). The ACA actually requires two Exchanges, one for small businesses and

---

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

one for individuals, which may be administratively operated as one entity. If a state elects not to establish an Exchange, the federal government will operate one either directly or through an agreement with a non-profit entity. The Exchange's functions must include:

- facilitating the purchase of qualified health plans by individuals and small groups;
- certifying health plans as qualified health plans based on federal guidelines;
- providing information to individuals about their eligibility for public programs like Medicaid and the Children's Health Insurance Program and enrolling eligible individuals in those programs;
- operating a telephone hotline and website to assist consumers in the Exchange; and
- establishing navigator programs to help inform consumers and facilitate their enrollment in qualified health plans in the Exchange.

The ACA specifies four categories of plans to be offered through the Exchange and in the individual and small group markets. The categories are based on the actuarial value of the plans; i.e., the percentage of the costs the plan is expected to pay:

- Platinum: 90 percent actuarial value;
- Gold: 80 percent actuarial value;
- Silver: 70 percent actuarial value; and
- Bronze: 60 percent actuarial value.

The ACA provides states with some flexibility when implementing an Exchange. For example:

- Basic Health Option (BHO): the state may contract with private insurers to provide coverage for low-income individuals between 133 and 200 percent federal poverty level, similar to Washington's existing Basic Health Plan. Individuals in the BHO will not participate in the Exchange, but the state will receive federal funding for the BHO equal to 95 percent of the tax credits and cost-sharing reductions the individuals would have received in the Exchange.
- Regional or Interstate Exchange: an Exchange may operate in more than one state. A state may also establish subsidiary Exchanges to serve geographically distinct areas within the state.
- One Exchange or Two: the state may operate separate Exchanges for the individual and small group markets, or may operate one Exchange that serves both (this is a separate issue from combining risk pools).
- Combining Risk Pools: the state may merge the individual and small group markets.
- Essential Health Benefits: the state may require insurers to offer benefits beyond what is required by federal law, but must pay for the increased costs of such benefits.

In 2011 the Legislature established its Exchange as a public-private partnership separate from the state. The Exchange is to begin operations by January 1, 2014, consistent with federal law and statutory authorization. The Exchange is governed by a nine-member board appointed by the Governor from a list submitted by all four caucuses of the House and the Senate. The powers and duties of the Exchange and the board are limited to those necessary to apply for and administer grants, establish information technology infrastructure, and other administrative functions. Any actions relating to substantive policy decisions must be made consistent with statutory direction.

II. Qualified Health Plans.

Only qualified health plans may sell insurance in the Exchange. In order to be a qualified health plan, a carrier must, at a minimum:

- be certified as a qualified health plan based on federal guidelines;
- provide coverage for the essential health benefits;
- offer at least one Silver and one Gold plan in the Exchange; and
- charge the same premium, both inside and outside the Exchange.

III. Catastrophic Plans.

Under the ACA, health plans may offer catastrophic plans to individuals inside and outside of the Exchange. Catastrophic plans are subject to an annual deductible of $5,950 for individuals and $11,900 for families (the deductible does not apply to preventive benefits and up to three primary care visits). The plans are only available to individuals who are both under the age of 31 and exempt from the individual mandate.

Under state law, a catastrophic health plan is defined as:

- a health plan requiring a calendar year deductible of at least $1,880 for individuals ($3,760 for multiple persons) and an annual out-of-pocket expense required for covered benefits of $3,760 for individuals ($6,450 for multiple persons); or
- a health plan that provides benefits for hospital inpatient and outpatient services, provides benefits for professional and prescription drugs provided in conjunction with the hospital services, and excludes or substantially limits outpatient physician services and those services usually provided in an office setting.

IV. Managing Risk.

The ACA contains a variety of mechanisms to address adverse selection both inside and outside of the Exchange, including:

- the individual mandate;
- authorizing open enrollment periods; and
- requiring health carriers to pool risk both inside and outside of the Exchange.

In addition, the ACA creates two temporary and one permanent risk leveling mechanisms:

- Reinsurance: a temporary program administered by the state nonprofit entity, the Reinsurance mechanism requires most health plans (both inside and outside the Exchange) to make payments to the non-profit entity that will then disburse those funds to plans with higher-risk enrollees.
- Risk Corridors: a temporary program administered by the federal government, the Risk Corridor mechanism is designed to compensate for the difficulty of establishing initial rates in the Exchange. Plans that have lower than expected costs will make payments to the federal government. The federal government will then disburse those funds to plans with higher than expected costs.
- Risk Adjustment: a permanent plan administered by the states, the Risk Adjustment mechanism assesses plans with lower-cost enrollees and makes disbursements to plans with higher-cost enrollees.

V. The Washington State Health Insurance Pool.

Before purchasing insurance on the individual market, Washington residents must complete the Standard Health Questionnaire. Based on the results, an individual may be turned down for coverage. The Washington State Health Insurance Pool (WSHIP) provides health insurance to individuals who have been rejected from the individual market for medical reasons. A WSHIP insurance plan may impose a six month waiting period for preexisting conditions. Premiums for WSHIP plans must be between 110 percent and 150 percent of what the largest carriers charge for individual plans with similar benefits.

Summary of Bill:

I. Health Insurance Exchanges.

Provisions limiting the authority of the Exchange Board (Board) are eliminated. The Exchange is required to report its activities to the Governor and the Legislature as requested, but no less often than annually. The Office of the Insurance Commissioner retains regulatory authority over health plans sold in the Exchange.

A designee of the Exchange, in addition to the Exchange itself, may authorize expenditures from the Health Benefit Exchange Account.

II. Qualified Health Plans.

The Board must certify a health plan as a qualified health plan if the plan:

- is determined by the Insurance Commissioner as meeting state insurance laws and regulations;
- is determined by the Board to meet the requirements of the ACA; and
- is determined by the Board to meet any additional requirements adopted by the Insurance Commissioner at the request of the Board.

Any additional requirements adopted by the Insurance Commissioner at the request of the Board should prioritize the interest of individuals and small businesses served by the Exchange and be intended to encourage:

- carriers to offer health plans in the Exchange;
- enrollment in plans in the Exchange of a diverse population with a range of health care needs;
- competition among carriers based on quality, price, and service; and
- a variety of plan choices among benefit tier levels.

A state agency must provide information upon request of the Board for its use in certifying a qualified health plan. The agency must provide the requested information within 60 days, unless another deadline is agreed to by the agency and the Board. The Board must reimburse the agency for the costs of complying with the request within 180 days of receipt of the information.

A decision by the Board denying a request to certify a plan as a qualified health plan may be appealed pursuant to procedures adopted by the Board.

III. Catastrophic Health Plans.

Part of the current definition of "catastrophic health plan" is made applicable only to grandfathered health plans issued before January 1, 2014, and renewed thereafter. A grandfathered plan is a catastrophic health plan if it requires a calendar year deductible of at least $1,880 for individuals ($3,760 for multiple persons) and an annual out-of-pocket expense required for covered benefits of $3,760 for individuals ($6,450 for multiple persons). The part of the definition dealing with a health plan that (1) provides benefits for hospital inpatient and outpatient services, (2) provides benefits for professional and prescription drugs provided in conjunction with the hospital services, and (3) excludes or substantially limits outpatient physician services and those services usually provided in an office setting, is eliminated.

For non-grandfathered health plans issued on or after January 1, 2014, a "catastrophic health plan" is defined as:

- a health plan that meets the definition in the ACA; or
- a health benefit plan offered outside the Exchange that requires a calendar year deductible or out-of-pocket expenses for covered benefits that requires a calendar year deductible of at least $1,880 for individuals ($3,760 for multiple persons) and an annual out-of-pocket expense required for covered benefits of $3,760 for individuals ($6,450 for multiple persons).

IV. Managing Risk.

A carrier may not:

- offer an individual or small group health plan outside the Exchange unless it also offers a Silver and Gold level individual or small group health plan inside the Exchange;
- offer a non-grandfathered catastrophic health benefit plan outside the Exchange unless it offers the same plan inside the Exchange;
- offer outside the Exchange a catastrophic health plan (as defined by the ACA) with a benefit design that includes covering three primary care visits regardless of whether the deductible has been satisfied;
- offer a Bronze level health plan outside the Exchange unless it offers the same plan inside the Exchange.

The Insurance Commissioner may enforce these restrictions by:

- issuing a cease and desist order;
- imposing a penalty of $25,000; or
- suspending or revoking the carrier's certificate of authority or certificate of registration.

V. The Washington State Health Insurance Pool.

Beginning on January 1, 2014, a person is eligible for coverage in the WSHIP only if he or she is enrolled in pool coverage on December 31, 2013, and does not disenroll after December 31, 2013. For policies renewed on or after January 1, 2014, rates for pool coverage may be no more than the average individual standard rate charged for comparable coverage by the five largest carriers, measured in terms of individual market enrollment, in the state. If five carriers do not offer comparable coverage, the rates may be no greater than the standard risk rate established using reasonable actuarial techniques and must reflect anticipated experience and expenses for such coverage in the individual market. A WSHIP plan may not impose a pre-existing condition waiting period that extends beyond December 31, 2013.

Appropriation: None.

Fiscal Note: Requested on January 11, 2012.

Effective Date: This bill takes effect 90 days after adjournment of the session in which the bill is passed, except for sections 8 and 9 relating to the powers of the Exchange Board and the Health Benefit Exchange Account, which contact an emergency clause and take effect immediately; and section 10, 12, and 14 relating to WSHIP eligibility, which takes effect on January 1, 2014.